Good Care, Bad Documentation

The Medical Malpractice Perspective

Agenda

- Why maintain a chart?
  - Contents
  - Purpose
- General Housekeeping
- Specific Tips

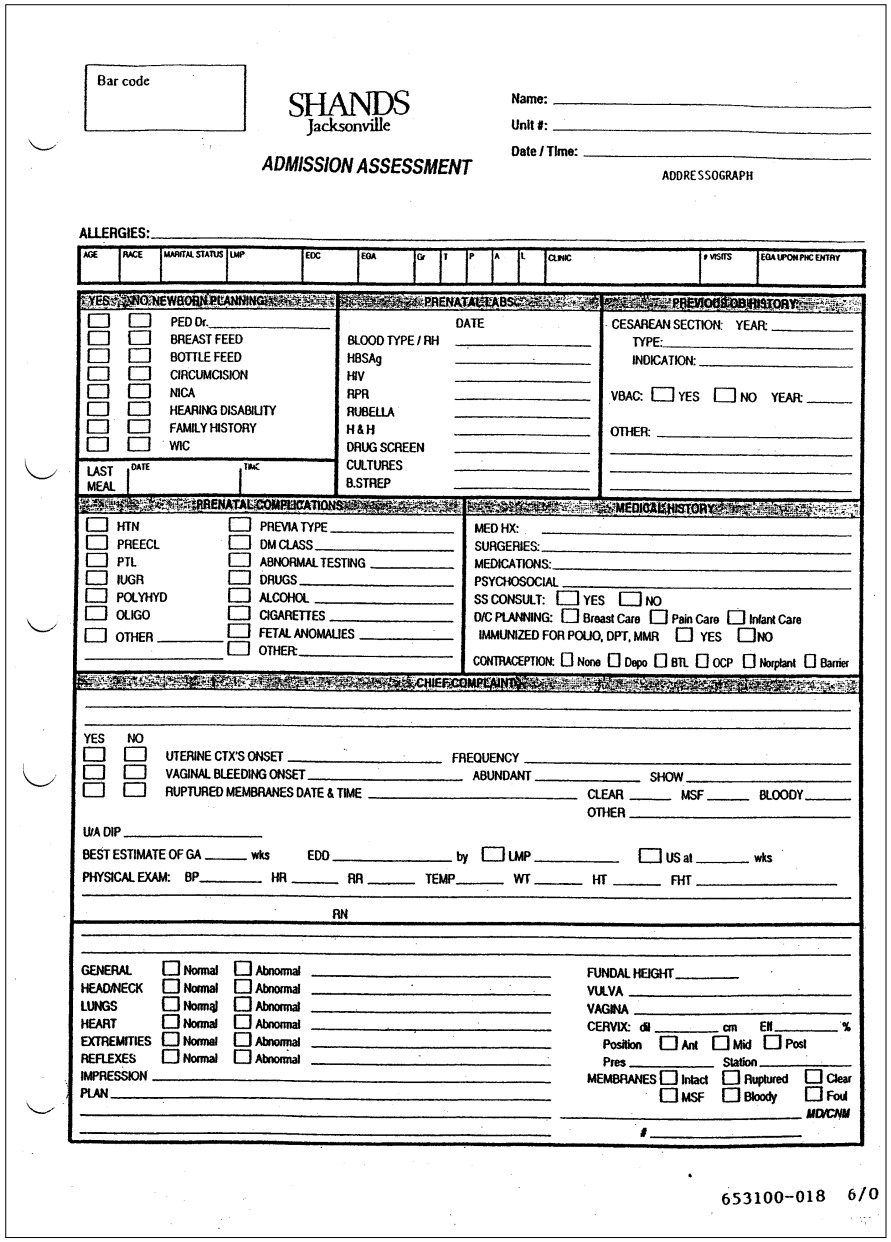
Why Maintain a Chart?

- Preserves information that will:
  - Facilitate continuity of care
  - Help defend caregivers in medical case
  - Provide information needed to facilitate finding of competence or incompetence in legal hearing
  - Identify treatments employed/conditions treated which facilitates reimbursement
  - Provide needed documentation to support qualification of patients for potential disability benefits

Chart Contents

- Clinically significant information
  - Initial assessments
  - Follow-up assessments
  - Evaluations to treatments
  - Responses to treatments
  - Consent documentation
- Key communications

Evaluations



Bar code

SHANDS Jacksonville

ADMISSION ASSESSMENT

Name: _____
Unit #: _____
Date / Time: _____
ADDRESSOGRAPH

ALLERGIES: _____

AGE	RACE	MARITAL STATUS	LMP	EDC	EGA	Gr	T	P	A	L	CLINIC	# VISITS	EGA UPON PHC ENTRY

NEWBORN PLANNING

YES	NO	
☐	☐	PED Dr._____
☐	☐	BREAST FEED
☐	☐	BOTTLE FEED
☐	☐	CIRCUMCISION
☐	☐	NICA
☐	☐	HEARING DISABILITY
☐	☐	FAMILY HISTORY
☐	☐	WIC

LAST MEAL DATE TIME

PRENATAL LABS

	DATE
BLOOD TYPE / RH	
HBSAg	
HIV	
RPR	
RUBELLA	
H & H	
DRUG SCREEN	
CULTURES	
B.STREP	

PREVIOUS OB HISTORY

CESAREAN SECTION: YEAR: _____
TYPE: _____
INDICATION: _____

VBAC: ☐ YES ☐ NO YEAR: _____

OTHER: _____

PRENATAL COMPLICATIONS

☐ HTN	☐ PREVIA TYPE _____
☐ PREECL	☐ DM CLASS _____
☐ PTL	☐ ABNORMAL TESTING _____
☐ IUGR	☐ DRUGS _____
☐ POLYHYD	☐ ALCOHOL _____
☐ OLIGO	☐ CIGARETTES _____
☐ OTHER _____	☐ FETAL ANOMALIES _____
	☐ OTHER: _____

MEDICAL HISTORY

MED HX: _____
SURGERIES: _____
MEDICATIONS: _____
PSYCHOSOCIAL _____
SS CONSULT: ☐ YES ☐ NO
D/C PLANNING: ☐ Breast Care ☐ Pain Care ☐ Infant Care
IMMUNIZED FOR POLIO, DPT, MMR ☐ YES ☐ NO
CONTRACEPTION: ☐ None ☐ Depo ☐ BTL ☐ OCP ☐ Norplant ☐ Barrier

CHIEF COMPLAINT

YES	NO	
☐	☐	UTERINE CTX'S ONSET _____ FREQUENCY _____
☐	☐	VAGINAL BLEEDING ONSET _____ ABUNDANT _____ SHOW _____
☐	☐	RUPTURED MEMBRANES DATE & TIME _____ CLEAR _____ MSF _____ BLOODY _____
		OTHER _____

U/A DIP _____

BEST ESTIMATE OF GA _____ wks EDD _____ by ☐ LMP _____ ☐ US at _____ wks

PHYSICAL EXAM: BP_____ HR _____ RR _____ TEMP_____ WT _____ HT _____ FHT _____

RN

GENERAL	☐ Normal	☐ Abnormal	_____
HEAD/NECK	☐ Normal	☐ Abnormal	_____
LUNGS	☐ Normal	☐ Abnormal	_____
HEART	☐ Normal	☐ Abnormal	_____
EXTREMITIES	☐ Normal	☐ Abnormal	_____
REFLEXES	☐ Normal	☐ Abnormal	_____

IMPRESSION _____
PLAN _____

FUNDAL HEIGHT _____
VULVA _____
VAGINA _____
CERVIX: dil _____ cm Eff _____ %
Position ☐ Ant ☐ Mid ☐ Post
Pres _____ Station _____
MEMBRANES ☐ Intact ☐ Ruptured ☐ Clear ☐ MSF ☐ Bloody ☐ Foul

MD/CNM
#

653100-018 6/0

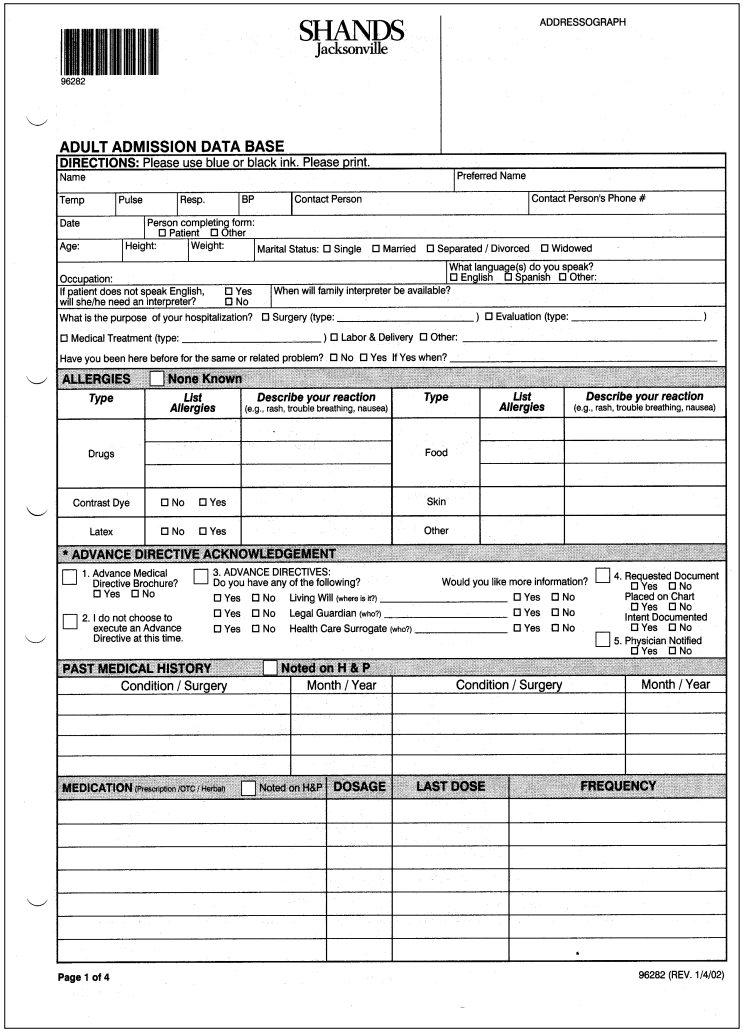
- Initial assessment
- Follow-up assessments
- Emergency assessments

Specific Tips

- Initial assessments
- Progress notes
- Consultations
- Procedure notes
- Treatment orders
- Late entries and addenda
- Specialty specific
- Documentation of adverse incidents
- Disagreements in the chart
- Chart integrity
- Consent

Initial Assessments

- Documentation of baseline data must include:
  - Date/time/signature
  - Statement regarding patient's reliability
  - Review of systems not just those involving impending delivery
  - Provisional diagnosis and the fact it was discussed with patient
  - If by resident, he/she should note that it was discussed with attending



96282

SHANDS Jacksonville

ADDRESSOGRAPH

ADULT ADMISSION DATA BASE

DIRECTIONS: Please use blue or black ink. Please print.

Name | Preferred Name

Temp | Pulse | Resp. | BP | Contact Person | Contact Person's Phone #

Date | Person completing form: ☐ Patient ☐ Other

Age: | Height: | Weight: | Marital Status: ☐ Single ☐ Married ☐ Separated / Divorced ☐ Widowed

Occupation: | What language(s) do you speak? ☐ English ☐ Spanish ☐ Other:

If patient does not speak English, will she/he need an interpreter? ☐ Yes ☐ No | When will family interpreter be available?

What is the purpose of your hospitalization? ☐ Surgery (type: _____) ☐ Evaluation (type: _____)

☐ Medical Treatment (type: _____) ☐ Labor & Delivery ☐ Other: _____

Have you been here before for the same or related problem? ☐ No ☐ Yes If Yes when? _____

ALLERGIES ☐ None Known

Type	List Allergies	Describe your reaction (e.g., rash, trouble breathing, nausea)	Type	List Allergies	Describe your reaction (e.g., rash, trouble breathing, nausea)
Drugs			Food		
Contrast Dye	☐ No ☐ Yes		Skin		
Latex	☐ No ☐ Yes		Other		

*** ADVANCE DIRECTIVE ACKNOWLEDGEMENT**

☐ 1. Advance Medical Directive Brochure? ☐ Yes ☐ No

☐ 2. I do not choose to execute an Advance Directive at this time.

☐ 3. ADVANCE DIRECTIVES: Do you have any of the following? Would you like more information?
- ☐ Yes ☐ No Living Will (where is it?) _____ ☐ Yes ☐ No
- ☐ Yes ☐ No Legal Guardian (who?) _____ ☐ Yes ☐ No
- ☐ Yes ☐ No Health Care Surrogate (who?) _____ ☐ Yes ☐ No

☐ 4. Requested Document ☐ Yes ☐ No
Placed on Chart ☐ Yes ☐ No
Intent Documented ☐ Yes ☐ No

☐ 5. Physician Notified ☐ Yes ☐ No

PAST MEDICAL HISTORY ☐ Noted on H & P

Condition / Surgery	Month / Year	Condition / Surgery	Month / Year

MEDICATION (Prescription /OTC / Herbal) ☐ Noted on H&P	DOSAGE	LAST DOSE	FREQUENCY

Page 1 of 4

96282 (REV. 1/4/02)

Progress Notes

- Should reflect day to day account of patient's treatments/conditions
- Each note should reflect:
  - Specificity
  - Objectivity
  - Comprehensiveness
  - Informativeness
  - Communication with patient
  - Completeness

Consultations

- All consultations should be requested in writing and provide summary of medical information available
- Consultants should note how/when they were notified of consult
- Consultants should note patient was seen, when seen and when full consultative summary will be available
- Primary attending should note that consultants' recommendations were reviewed, and if not followed, should clearly/objectively state reason(s)

Procedure Notes

- Document all procedures/treatments
- Documentation must include:
  - Date/time/signature
  - Name of procedure
  - Names of persons who performed and/or assisted
  - Technique used/site
  - Indications for procedure
  - Findings of procedure
  - Specimens taken/disposition
  - Complications that occurred/how treated

Treatment Orders

- Reflect treatment plan outlined in H&P, consulting notes, and progress notes.
- Orders should be written completely and accurately to avoid error – *legibility is critical*
- Date/time/sign all orders
- When ordering drugs use *drug, dose, route and frequency*
- Avoid abbreviations not approved by facility

Treatments

- Given per order
- Given per policy
- If not given; why?

Response to Treatment

- Improvement in variability
- Resolution of decelerations
- Return to normal labor progression
- Practitioner observations
  - Clinically significant signs and/or symptoms like changes in
    - ✓FMS findings
    - ✓Dilation
    - ✓Vital signs
    - ✓Strength/frequency of contractions
    - ✓Mental status

Key Communications

- Verbal/non-verbal communications by patient
  - Particularly critical to accurately record patient's description of subjective condition (i.e., hard to breathe, pain)
- Verbal/written communications with other practitioners
  - Written and telephone orders
  - Thought process
  - Updates on deteriorating conditions
  - Patient's response to treatments or lack thereof
- Informed consent

Housekeeping

- Full name and unit number on all pages
- Date, time and signature of caregiver on all notes; *consistent times*
- Use black/blue ballpoint pen
- Entries must be legible
- Entries should be contemporaneous

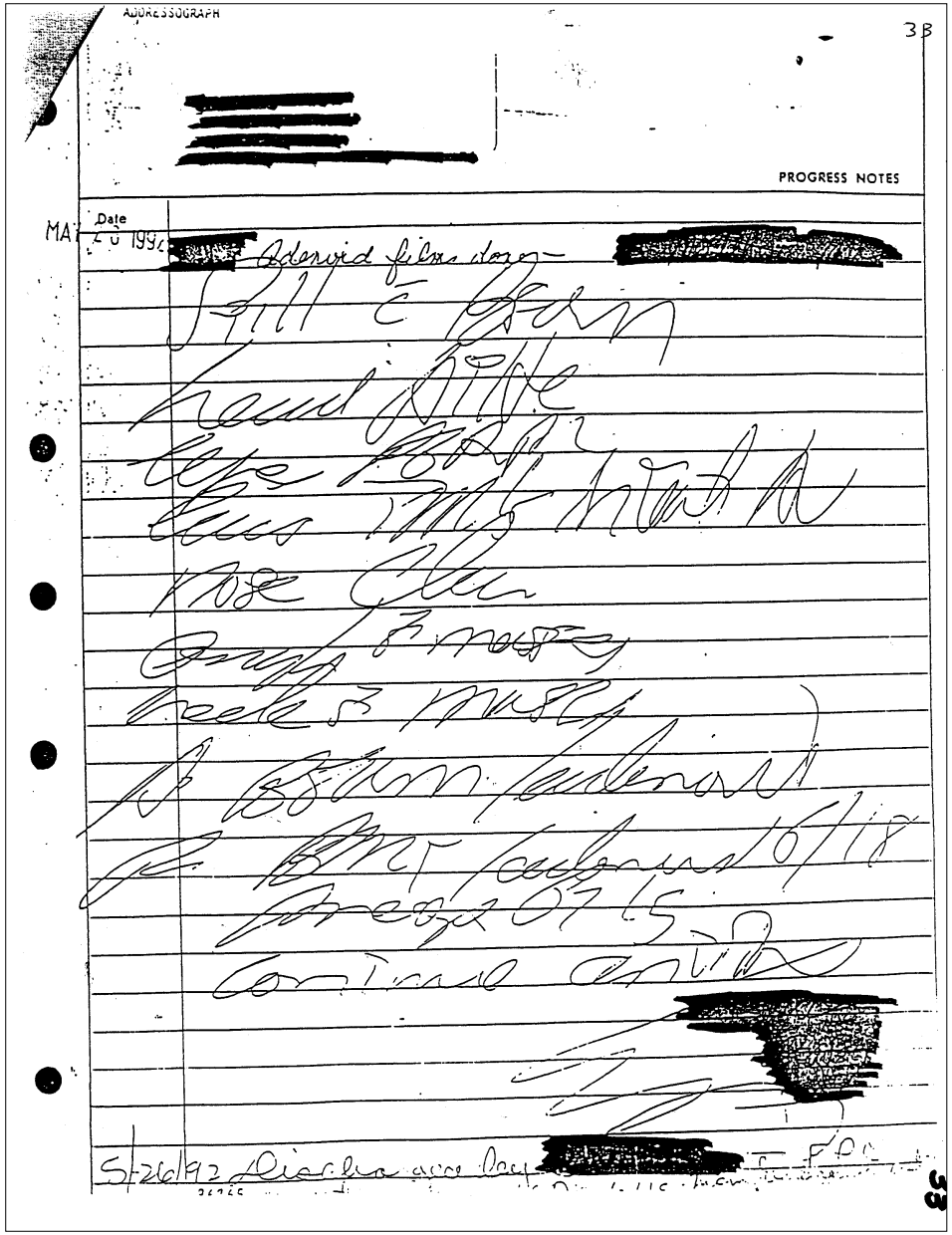
Examples: Timing

- 2:00 PM patient awake, alert and appropriate, in

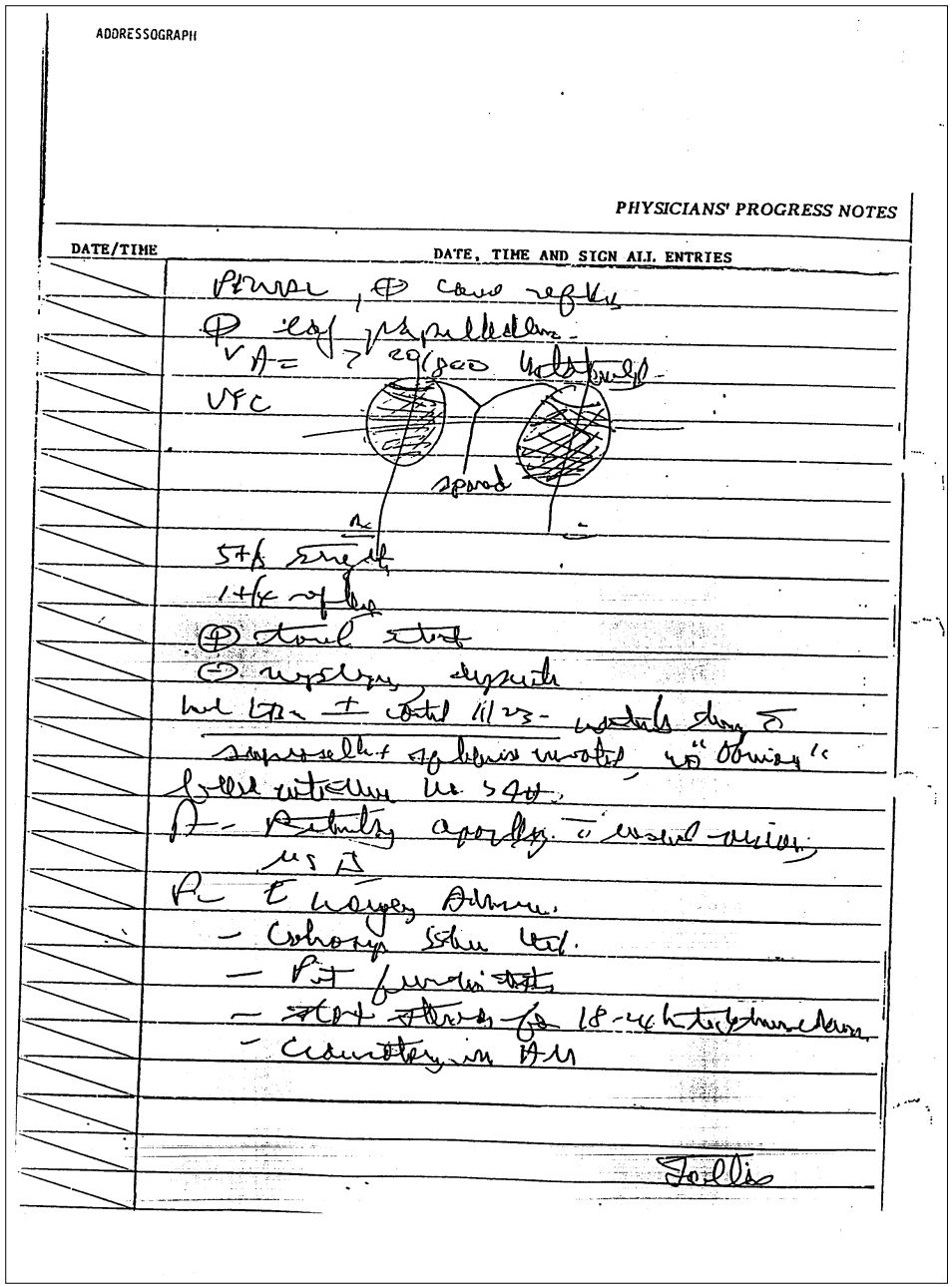
- 13:30 patient found unconscious, CPR initiated, unable to resuscitate

Examples: Legibility

Can you read this?

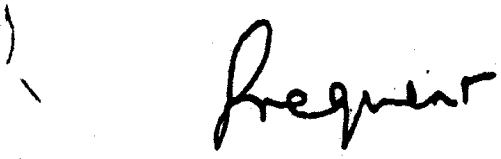


Examples: Legibility



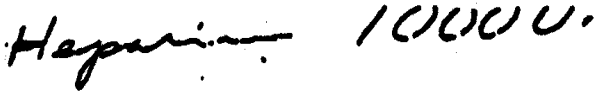
Or this?

Examples: Legibility

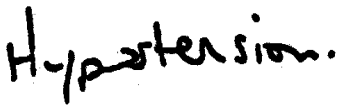


Is this urine *pregnant* or *frequent*?

Is this VDRL *routine* or *positive*?



Is this order for 1,000 units or 10,000 units?



Is this patient *hypertensive* or *hypotensive*?

Is this liver *negative* or is there *hepatitis*?

Housekeeping

- Information documented should be
  - Objective
  - Non-judgmental
  - Factual
  - Correct

Housekeeping

ADDRESSOGRAPH

NURSING SERVICE
OPERATIVE CHECKLIST

Evening Prior to Surgery

- [x] History and Physical complete
- [x] Identaband on arm
- [x] Laboratory reports — [x] Urinalysis — [x] Blood — [x] X-Ray — [x] EKG
- [ ] Blood available in Lab, If applicable — in computer 11/28/89
- [x] Informed consent signed and witnessed
- [x] NPO sign over bed
- [x] Instructed on NPO after midnight
- [x] NPO slip or diet modification to Dietary
- [x] Special preparation — [ ] Enema [ ] Douche [ ] Sedation
  Proper Antiseptic Bath Administered
- [x] Instructed on coughing and deep breathing
- [x] Explained routine RR care
- [x] Verbalized or demonstrated understanding of pre-operative teaching
- [x] Remove nail polish
- [ ] Valuables to Security_____
- [x] Blood ordered crossmatch
- [ ] Permission for transfusion obtained? (required if blood ordered crossmatched? N/A) N/A

Nurse' Signature__

Morning of Surgery

- [x] Patient's name, identaband and chart correspond
- [x] Bath, shower, oral hygiene
- [x] All Personal Clothing removed and hospital gown applied
- [x] Hair pin, hair roller, jewelry, makeup, nail polish removed
- [x] Prosthesis removed, dentures, etc.
- [x] Medication and graphic sheet on chart
- [x] Vital signs recorded, T.P.R., B/P
- [ ] Bladder empty
- [ ] IV started, if applicable

  Solution_____ Angiocath# _____

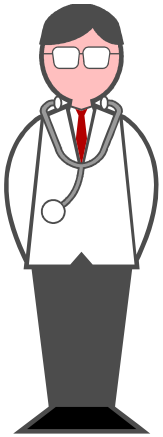
  Nurse starting IV_____

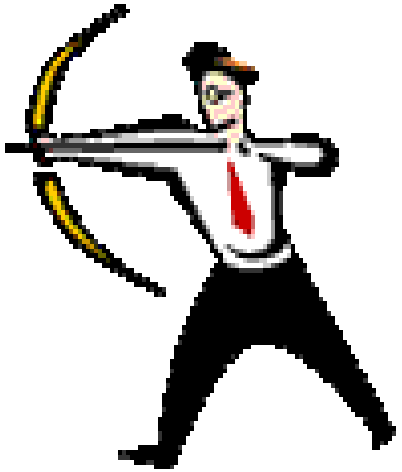
- [x] Pre-op medication: include time, site and route p.o. @ 0600am Zantac 150mg Reglan 10mg.
- [ ] Blood ordered crossmatched?

95745 rev. 12/89 (over)

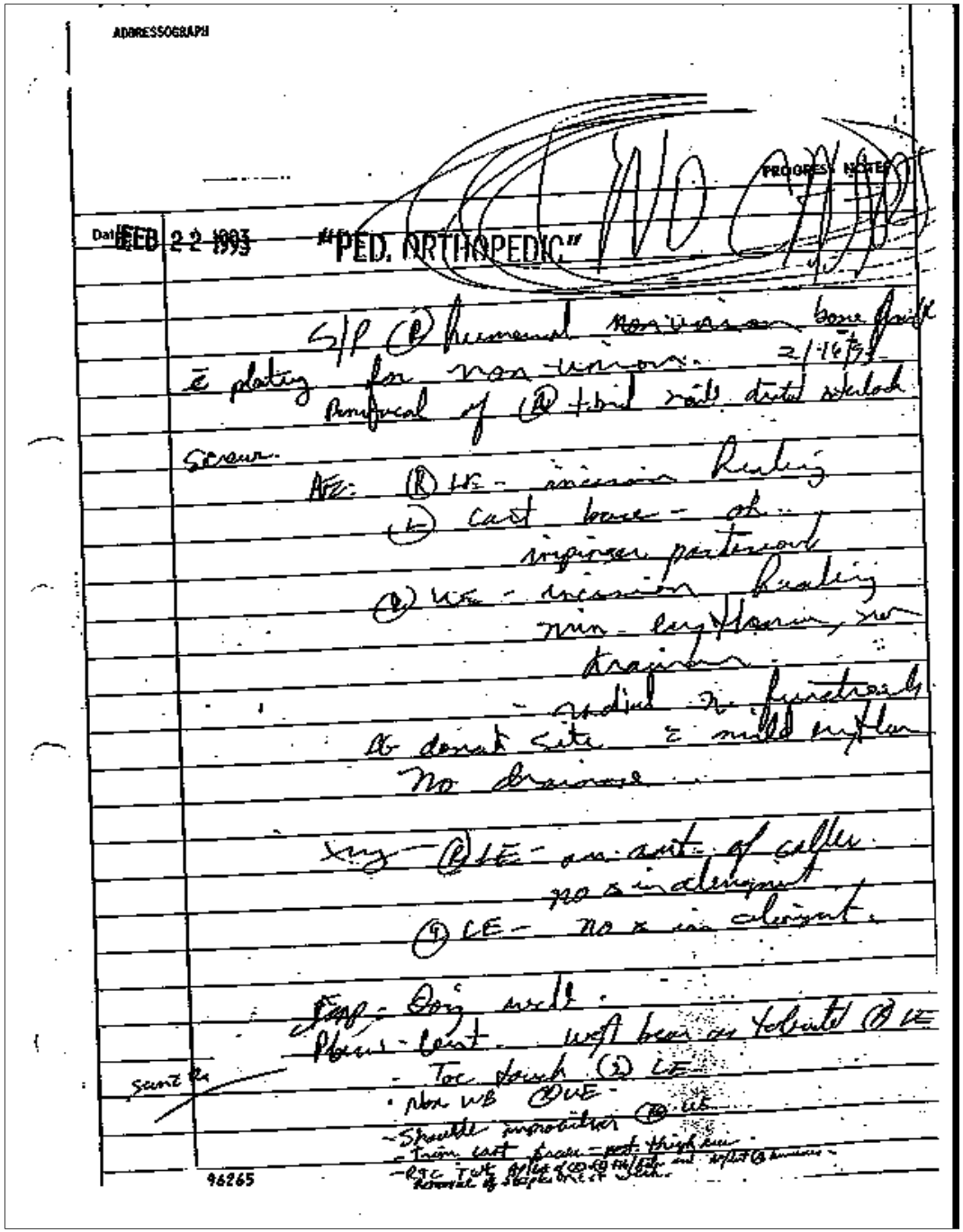
Housekeeping

- Never use the chart to:
  - Stereotype
  - Demean
  - Document personal issues
    - ✓Staffing shortages
    - ✓Equipment problems
    - ✓Confrontations – “arrow in the heart”





Examples: "Arrows"



ADDRESSOGRAPH

PROGRESS NOTES

Date FEB 2 2 1993 "PED. ORTHOPEDIC"

S/P (R) humeral non-union bone graft
& plating for non-union. 2/16/93
Removal of (R) tibial rod distal interlock
screws.

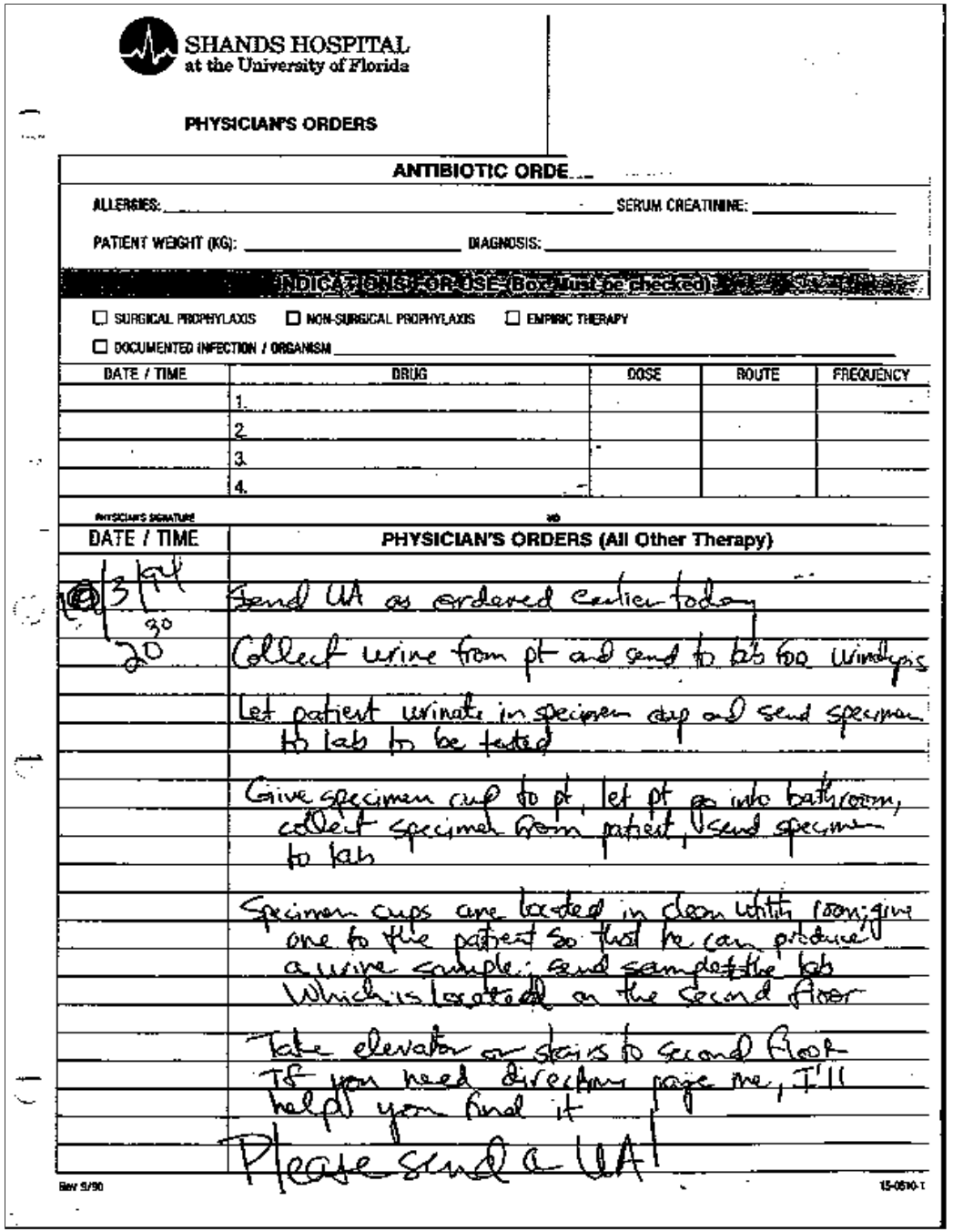
Exam: (R) UE - incision healing
(L) cast brace - ok
improper patient
(R) UE - incision healing
min - lacy Homan, no
drainage
- pulses & function
at donor site & mild myalgia
No bruising

Xray - (R) UE - one cort. of callus
no x in alignment
(L) UE - no x in alignment

Exp - Doing well.
Plan - Cont. wt bear on tolerated (R) UE
- Toe touch (L) LE
- Non WB (R) UE
- Shoulder exercises (R) UE
- Incision care from - post thigh area
- R/C Tx's

96265

Examples: "Arrows"



SHANDS HOSPITAL
at the University of Florida

PHYSICIAN'S ORDERS

ANTIBIOTIC ORDE...

ALLERGIES: _____ SERUM CREATININE: _____

PATIENT WEIGHT (KG): _____ DIAGNOSIS: _____

INDICATIONS FOR USE (Box must be checked)

☐ SURGICAL PROPHYLAXIS ☐ NON-SURGICAL PROPHYLAXIS ☐ EMPIRIC THERAPY

☐ DOCUMENTED INFECTION / ORGANISM _____

DATE / TIME	DRUG	DOSE	ROUTE	FREQUENCY
	1.			
	2.			
	3.			
	4.			

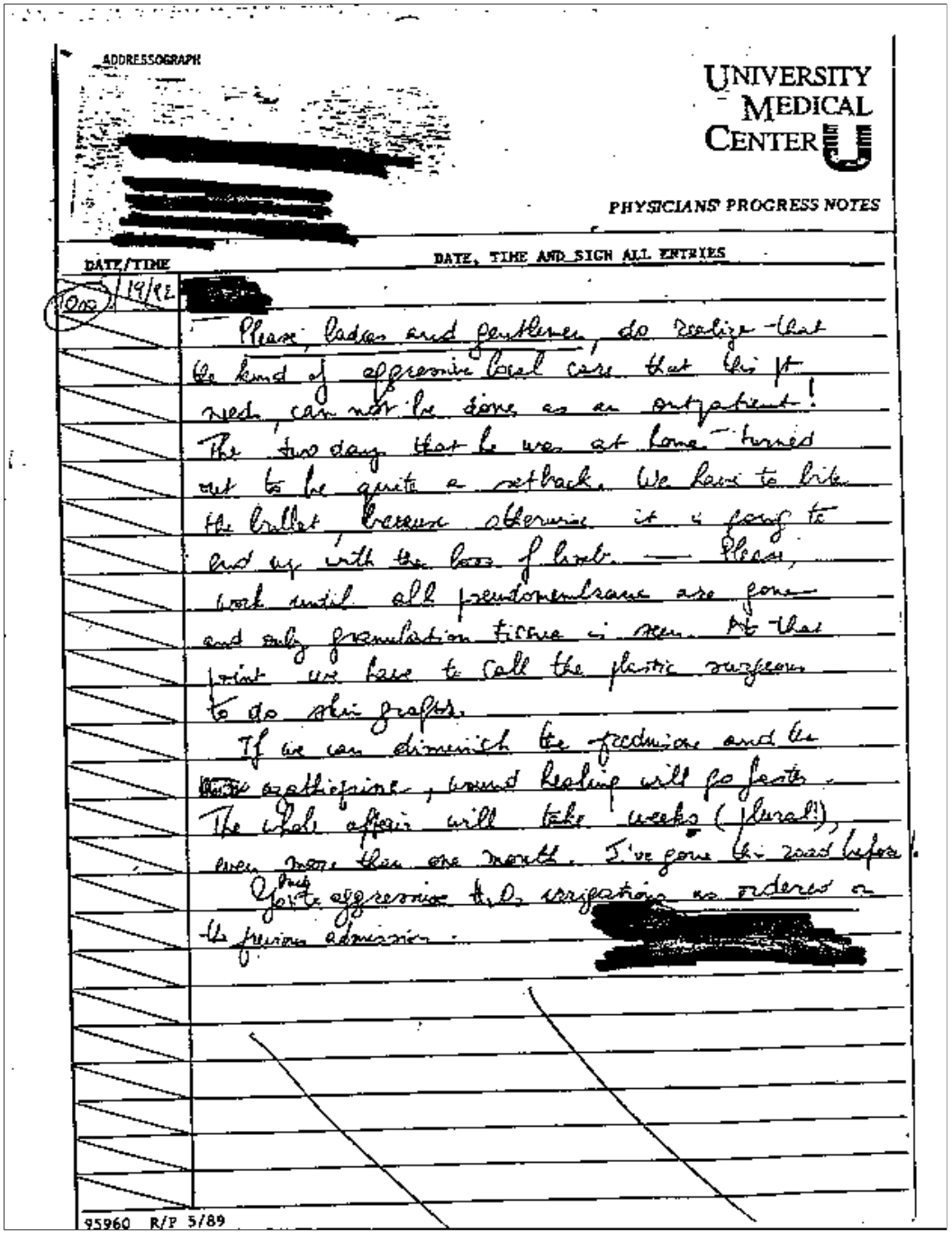
PHYSICIAN'S SIGNATURE

DATE / TIME	PHYSICIAN'S ORDERS (All Other Therapy)
@ 3 pm	Send UA as ordered earlier today
30 20	Collect urine from pt and send to lab for Windlyns
	Let patient urinate in specimen cup and send specimen to lab to be tested
	Give specimen cup to pt, let pt go into bathroom, collect specimen from patient, send specimen to lab
	Specimen cups are located in clean utility room; give one to the patient so that he can produce a urine sample; send sample to the lab which is located on the second floor
	Take elevator or stairs to second floor. If you need directions page me, I'll help you find it
	Please send a UA!

Rev 5/90

15-0510-1

Examples: "Arrows"



ADDRESSOGRAPH

[redacted]

UNIVERSITY MEDICAL CENTER

PHYSICIANS' PROGRESS NOTES

DATE/TIME — DATE, TIME AND SIGN ALL ENTRIES

1900 | 10/12 [redacted]

Please, ladies and gentlemen, do realize that the kind of aggressive local care that this pt needs, can not be done as an outpatient! The two days that he was at home turned out to be quite a setback. We have to bite the bullet, because otherwise it is going to end up with the loss of limb. — Please, work until all pseudomembrane are gone and only granulation tissue is seen. At that point we have to call the plastic surgeons to do skin grafts.

If we can diminish the edema and the cellulitis, wound healing will go faster. The whole affair will take weeks (plural!), even more than one month. I've gone to Board before!

Pt's aggressive H.O. irrigations as ordered on the previous admission.

[redacted]

95960 R/P 5/89

Housekeeping

- Don’t leave blank spaces in forms or flow charts
- Don’t make personal copies of chart or RAQ report
- Don’t reference completion of RAQ or write “called risk management” in chart
- Don’t make personal notes unless so directed by Risk Management
- Don’t alter the chart
  - Corrections are OK if done properly
  - Appropriate addendums are also OK

Appropriate Alterations

- To correct an entry
  - Draw straight line through incorrect data so it can still be seen
  - Enter correct information above or below
  - Date and initial correction
- Addendums are OK but must
  - Be dated/timed to show when note was made
  - Should include reason note made late

Inappropriate Chart Alterations

- 2nd degree misdemeanor
  - Jail not to exceed 60 days and/or
  - Fine of not greater than $500.00

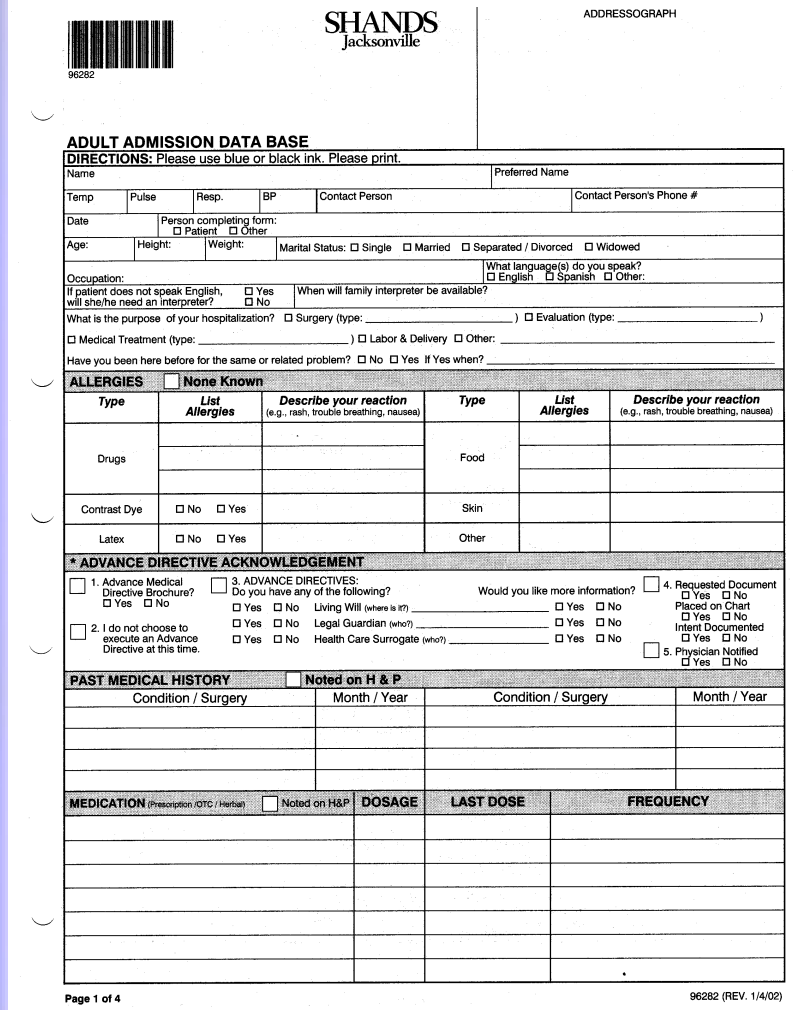
Specialty Considerations

Women's & Children's Services

General Tips

- Date/time/sign each entry into the record
- Completely document results of every examination
- Evidence of continuing monitoring and evaluation of patient, including interpretation of fetal monitoring
- All consent discussions with patient (parents, if infant/child) to include internal monitoring, fetal scalp sampling, C-section and anesthesia
- Support analysis for any management decisions for use of trial labor, artificial ROM, decelerations of heart rate, use of oxytocin, or any decision to intervene or not intervene in the natural course of labor and delivery

Admission Database



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ADDRESSOGRAPH

ADULT ADMISSION DATA BASE

DIRECTIONS: Please use blue or black ink. Please print.

Name | Preferred Name

Temp | Pulse | Resp. | BP | Contact Person | Contact Person's Phone #

Date | Person completing form: ☐ Patient ☐ Other

Age: | Height: | Weight: | Marital Status: ☐ Single ☐ Married ☐ Separated / Divorced ☐ Widowed

Occupation: | What language(s) do you speak? ☐ English ☐ Spanish ☐ Other:

If patient does not speak English, will she/he need an interpreter? ☐ Yes ☐ No | When will family interpreter be available?

What is the purpose of your hospitalization? ☐ Surgery (type: _____) ☐ Evaluation (type: _____)

☐ Medical Treatment (type: _____) ☐ Labor & Delivery ☐ Other: _____

Have you been here before for the same or related problem? ☐ No ☐ Yes If Yes when? _____

ALLERGIES ☐ None Known

Type	List Allergies	Describe your reaction (e.g., rash, trouble breathing, nausea)	Type	List Allergies	Describe your reaction (e.g., rash, trouble breathing, nausea)
Drugs			Food		
Contrast Dye	☐ No ☐ Yes		Skin		
Latex	☐ No ☐ Yes		Other		

*** ADVANCE DIRECTIVE ACKNOWLEDGEMENT**

☐ 1. Advance Medical Directive Brochure? ☐ Yes ☐ No

☐ 2. I do not choose to execute an Advance Directive at this time.

☐ 3. ADVANCE DIRECTIVES: Do you have any of the following? Would you like more information?

- ☐ Yes ☐ No Living Will (where is it?) _____ ☐ Yes ☐ No
- ☐ Yes ☐ No Legal Guardian (who?) _____ ☐ Yes ☐ No
- ☐ Yes ☐ No Health Care Surrogate (who?) _____ ☐ Yes ☐ No

☐ 4. Requested Document ☐ Yes ☐ No Placed on Chart ☐ Yes ☐ No Intent Documented ☐ Yes ☐ No

☐ 5. Physician Notified ☐ Yes ☐ No

PAST MEDICAL HISTORY ☐ Noted on H & P

Condition / Surgery	Month / Year	Condition / Surgery	Month / Year

MEDICATION (Prescription /OTC / Herbal) ☐ Noted on H&P	DOSAGE	LAST DOSE	FREQUENCY

Page 1 of 4

96282 (REV. 1/4/02)

SHANDS Jacksonville

ADDRESSOGRAPH

ADULT ADMISSION DATA BASE (✔ all that apply)

ORIENTED TO: ☐ Room ☐ Emergency Light ☐ Lights ☐ Side Rail Policy ☐ Phone ☐ Bed in Low Position ☐ Call Light ☐ Bed Controls ☐ Television ☐ Smoking Policy ☐ Visiting Hours ☐ Not Getting Out of Bed Without Assistance

VALUABLES Security Notified ☐ Yes ☐ No Given to: _____

HEALTH HABITS

	Yes	No	If YES, answer the following
Do you smoke?	☐	☐	Type: ☐ Cigarettes ☐ Cigar ☐ Pipe ☐ Chew\Dip
If quit, when?			How many years? _____ How many packs? _____
Does anyone in the house smoke?	☐	☐	
Do you drink alcohol?	☐	☐	How often? ☐ Daily ☐ Weekly ☐ Monthly
			How many drinks? ☐ 1 - 2 ☐ 3 - 5 ☐ over 5
Do you use recreational or street drugs?	☐	☐	Type: ☐ Marijuana ☐ Cocaine\Crack
			☐ Others (list: _____)
Do you use holistic or alternative health providers or treatments (e.g., acupuncture, home or natural remedies) ?	☐	☐	When was the last time you used? _____

SOCIAL ISSUES

Which of the following do you do to cope with stress?

☐ Talk to someone\who? _____ ☐ Keep to myself ☐ Seek spiritual support ☐ Exercise

☐ Do an activity - what? _____ ☐ Leisure activity - what? _____ ☐ Seek Information

☐ Eat ☐ Drink alcohol ☐ Smoke ☐ Drugs ☐ Other _____

Social Support System			**Phone #**
Spouse	☐ Yes	☐ No	_____
Significant Other	☐ Yes	☐ No	_____
Family in same residence	☐ Yes	☐ No	_____
Family out of state	☐ Yes	☐ No	_____
Family Local	☐ Yes	☐ No	_____

Do you feel safe? ☐ Yes ☐ No

Do you have any concerns regarding your home, family, or finances during hospitalization? ☐ Yes ☐ No

Have you traveled recently? ☐ Yes ☐ No

Where? _____

Family Member/Significant Other Contributing to Form

Date _____ Time _____

SIGNATURE

RN/LPN

Date _____ Time _____

SIGNATURE

FUNCTIONAL SCREENING OF DAILY ACTIVITIES

	Yes	No	If YES, answer the following:
Do you have trouble sleeping?	☐	☐	What do you do to help you sleep? _____

Do you need help doing the following:	Yes	No	***Who helps you with your care?***
Bathing\Grooming?	☐	☐	_____
Dressing\Undressing	☐	☐	***Which of these do you use?***
Eating\Drinking	☐	☐	☐ Wheelchair ☐ Bedside commode
Walking	☐	☐	☐ Cane ☐ Walker ☐ Crutches
Getting in and out of bed\chair	☐	☐	☐ Special bed type: _____
Using the bathroom	☐	☐	☐ Braces type: _____
Climbing stairs	☐	☐	Type: _____
Getting and taking medications	☐	☐	Where? _____ How often? _____
Do you have pain acute or chronic pain?	☐	☐	What do you do to decrease the pain? _____

Page 2 of 4

96282 (REV. 1/4/02)

Pg 1 – Advance Directives

Pg 2 - Valuables

Admission Database

GASTROINTESTINAL	ABDOMEN	BOWEL SOUNDS
☐ Swallowing Difficulty ☐ Chewing Difficulty ☐ Dentures: ☐ Upper ☐ Lowers ☐ Retainer with patient ☐ Yes ☐ No	☐ Soft ☐ Distended ☐ Firm ☐ Jaundice ☐ Hard	☐ Normal ☐ Hyperactive ☐ Absent ☐ Hypoactive

OSTOMY

☐ Colostomy ☐ Ileostomy ☐ Urinary
☐ Appliance _____
Size _____
Self Care ☐ Yes ☐ No If no, who provides care? _____
Ostomy Referral to Inpt Wound - Ostomy Management by HBOC _____

ELIMINATION

Bowel Habits BM's / day _____
Date of last BM _____
☐ Use of Laxatives ☐ Constipation
☐ Diarrhea ☐ Incontinence

CARDIOVASCULAR

Pulse P=Present A=Absent
Radial ☐ Right ☐ Left
Femoral ☐ Right ☐ Left
Heart Sounds
Regular ☐ Yes ☐ No
Irregular ☐ Yes ☐ No

Brachial	☐ R 1 2 3 4	☐ L 1 2 3 4
Posterior Tibial	☐ R 1 2 3 4	☐ L 1 2 3 4
Dorsalis Pedis	☐ R 1 2 3 4	☐ L 1 2 3 4

Rhythm _____
Comments:

GENITOURINARY / BLADDER HABITS

☐ WNL ☐ Oliguria
☐ Frequency ☐ Urgency
☐ Dysuria ☐ Hematuria
☐ Nocturia ☐ Retention
☐ Incontinency ☐ Assistive Devices
If yes explain _____

RESPIRATORY

☐ Use of Accessory Musc
☐ Use of Home O_2
☐ Shortness of Breath

NEUROLOGICAL / PSYCHOLOGICAL

☐ Appears Agitated
☐ Appears Depressed
☐ Appears Withdrawn
☐ Social interaction normal
☐ Verbal Response:
☐ Oriented
☐ Confused Conversation

Eyes Open:
☐ Spontaneous
☐ To Speech
☐ To Pain
☐ No Response

Limb Strength
Arm ☐ R 1 2 3 ☐ L 1 2 3
Leg ☐ R 1 2 3 ☐ L 1 2 3

HEARING

☐ WNL
☐ Impaired ☐ Right ☐ Left
☐ Hearing Aid ☐ Right ☐ Left

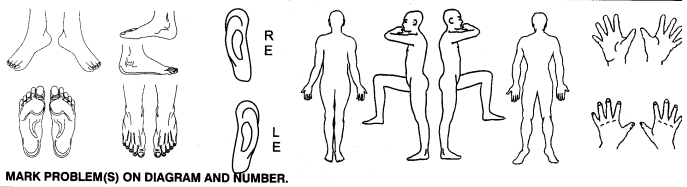
VISION

☐ WNL
☐ Eyeglasses ☐ Glaucoma
☐ Contacts ☐ Right ☐ Left ☐ Prosthesis
☐ Lens implants ☐ Right ☐ Left
☐ Cataracts ☐ Right ☐ Left

NORMALCY

☐ Religious Restrictions
☐ Cultural Restrictions
☐ Chaplain to Visit

ADMISSION SKIN - WOUND IDENTIFICATION



MARK PROBLEM(S) ON DIAGRAM AND NUMBER.

CATEGORY	SKIN RISK SCREEN: Score / Description				SCORE
Sensory Perception	1. Completely Limited	2. Very Limited	3. Slightly Limited	4. No Impairment	
Moisture	1. Constantly Moist	2. Often Moist	3. Occasionally Moist	4. Rarely Moist	
Activity	1. Bedfast	2. Chairfast	3. Walks Occasionally	4. Walks Frequently	
Mobility	1. Completely Immobile	2. Very Limited	3. Slightly Limited	4. No Limitations	
Nutrition	1. Very Poor	2. Probably Inadequate	3. Adequate	4. Excellent	
Friction and Shear	1. Problem	2. Potential Problem	3. No Apparent Problem		
					TOTAL

Total Score of equal to or less than 12 represents HIGH RISK and will result in:

☐ **A. Wound referral/Message to HBOC Printer WOCN**
☐ **B. Criteria Sheet (Special Bed)**
☐ **C. Completion of Pressure Ulcer Assessment Form**
☐ **D. Implementation of Prevention Protocol - Policy # N-01-098**
☐ **E. Pressure Ulcer Management - Policy # N-01-097**
☐ **No Problem Identified**

96282 (REV. 1/4/0

Pg 3 – Skin Assessment

CATEGORY	FALL RISK SCREEN: (Circle points in column for one or more indicators per category.) Maximum points per category listed in points column.	SCORE
Age	< 6 or > 75	(15)
Orientation	Disoriented person, place or time	(15)
IV Fluids	Continuous IV infusion	(5)
Post Anesthesia	Anesthesia within 48 hours	(5)
Stability	C/O pain, weakness or unsteadiness on feet	(5)
Medications	Receiving: diuretics, sedatives, hypnotic, narcotics, antiemetics, steroids antipsychotics, antihistamine, GI Motility, BP medications	(5)
Fall History	Previous history of falling	(15)
Contributing Factors	Positive history of postural hypotension, incontinence arthritis, visual problems, pulmonary problems	(5)
Mobility Aids	Uses mobility aid, requires assistance with mobility or bed, chair bound	(5)
IF TOTAL POINTS ARE 15 OR MORE * INITIATE FALL PREVENTION MEASURES, AS APPROPRIATE.		TOTAL:

Fall Prevention Measures Initiated ☐ Yes ☐ No Family / Patient given copy of Falls Information Sheet. ☐ Yes ☐ No

PATIENT EDUCATION

To help us plan your education, please answer the following questions. Language preference: _____
How do you learn best? (please ✔ all that apply) ☐ Reading ☐ Listening ☐ Watching video ☐ Watching someone ☐ Doing it myself ☐ Group classes ☐ Individual Instruction
Describe any problems you have that may effect learning:

COMPLETE SCREENS BELOW. (*Check all that apply*) Indicate any referrals made after all assessments complete.

Nutritional Screen

☐ Any unintentional weight loss
☐ Stage III or IV pressure ulcer
☐ Nausea, vomiting, diarrhea > 5 days
☐ Chewing/Swallowing difficulties
☐ Tube feeding / TPN
☐ 3 or more food allergies
Notify Nutritional Services if one or more checked
☐ Special diet followed:
☐ Yes ☐ No _____
☐ **Referral made and entered into HBOC by** _____ Initials
☐ No Problem Identified

Discharge Planning Screen

☐ **CATEGORY 1:** Minor medical condition or planned procedure without complication or comorbidity; normal functional level; identifiable living situation with family/support systems in place.
☐ **CATEGORY 2:** Minor medical condition or unplanned procedure with complication or comorbidity; normal functioning or minor impairment; identifiable living situation with family/support systems in place.
☐ **CATEGORY 3:** Major medical condition or procedure without complication or comorbidity; mild to moderate functional impairment; living situation may or may not be identifiable; support systems affected or questionable.
☐ **CATEGORY 4:** Major medical condition or procedure/multiple procedures with complication and/or comorbidity; moderate to severe functional impairment; living situation and support systems not known, not clear, or are questionable.
☐ **CATEGORY 5:** Catastrophic medical condition and/or multiple procedures with severe functional impairment; living situation and/or support systems drastically affected by disease process/hospitalization.

ENTER DISCHARGE PLANNING SCREEN CATEGORY IN HBOC SYSTEM

☐ **Referral made and entered into HBOC by** _____ Initials

Pharmacy Referral for:

☐ Difficulty taking medication
☐ Difficulty preparing medication
☐ Medication non-compliance
☐ Suspected adverse drug reaction
☐ Complex drug regimen
☐ **Referral made and entered into HBOC by** _____ Initials
☐ No Problem Identified

Pastoral Care Referral for:

☐ Religious practice impacting hospitalization
☐ Ethical concerns
☐ Relative or Significant other
☐ Coping or Grieving
☐ **Referral made and entered into HBOC by** _____ Initials
☐ No Problem Identified

Rehabilitation Screen

☐ **Referral made to Physical Therapy and entered into HBOC by** _____ Initials
☐ *Needs post hospital instruction for care
☐ *Needs assistance with ADL's, ambulation, mobility
☐ *Needs assistive devices, equipment
☐ *Needs assistance with speech and or swallowing problems
☐ **Referral made and entered into HBOC by** _____ Initials
☐ No Problem Identified

***Physician Order Required**

☐ Occupational Therapy
☐ Physical Therapy
☐ Speech Therapy

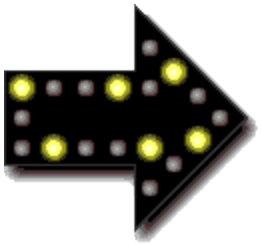
RN
Date _____ Time _____
SIGNATURE

RN
Date _____ Time _____
SIGNATURE

96282 (REV. 1/4/02)

Pg 4 – Falls Assessment

Admission Assessment



Look for prenatal records

Bar code

SHANDS Jacksonville

ADMISSION ASSESSMENT

Name: _____

Unit #: _____

Date / Time: _____

ADDRESSOGRAPH

ALLERGIES: _____

AGE	RACE	MARITAL STATUS	LMP	EDC	EGA	Gr	T	P	A	L	CLINIC	# VISITS	EGA UPON PNC ENTRY

NEWBORN PLANNING

YES	NO	
☐	☐	PED Dr._____
☐	☐	BREAST FEED
☐	☐	BOTTLE FEED
☐	☐	CIRCUMCISION
☐	☐	NICA
☐	☐	HEARING DISABILITY
☐	☐	FAMILY HISTORY
☐	☐	WIC

LAST MEAL DATE _____ TIME _____

PRENATAL LABS

	DATE
BLOOD TYPE / RH	
HBSAg	
HIV	
RPR	
RUBELLA	
H & H	
DRUG SCREEN	
CULTURES	
B.STREP	

PREVIOUS OB HISTORY

CESAREAN SECTION: YEAR: _____

TYPE: _____

INDICATION: _____

VBAC: ☐ YES ☐ NO YEAR: _____

OTHER: _____

PRENATAL COMPLICATIONS

☐ HTN	☐ PREVIA TYPE _____	
☐ PREECL	☐ DM CLASS _____	
☐ PTL	☐ ABNORMAL TESTING _____	
☐ IUGR	☐ DRUGS _____	
☐ POLYHYD	☐ ALCOHOL _____	
☐ OLIGO	☐ CIGARETTES _____	
☐ OTHER _____	☐ FETAL ANOMALIES _____	
	☐ OTHER: _____	

MEDICAL HISTORY

MED HX: _____

SURGERIES: _____

MEDICATIONS: _____

PSYCHOSOCIAL _____

SS CONSULT: ☐ YES ☐ NO

D/C PLANNING: ☐ Breast Care ☐ Pain Care ☐ Infant Care

IMMUNIZED FOR POLIO, DPT, MMR ☐ YES ☐ NO

CONTRACEPTION: ☐ None ☐ Depo ☐ BTL ☐ OCP ☐ Norplant ☐ Barrier

CHIEF COMPLAINT

_____

_____

YES	NO		
☐	☐	UTERINE CTX'S ONSET _____	FREQUENCY _____
☐	☐	VAGINAL BLEEDING ONSET _____	ABUNDANT _____ SHOW _____
☐	☐	RUPTURED MEMBRANES DATE & TIME _____	CLEAR _____ MSF _____ BLOODY _____
			OTHER _____

U/A DIP _____

BEST ESTIMATE OF GA _____ wks EDD _____ by ☐ LMP _____ ☐ US at _____ wks

PHYSICAL EXAM: BP _____ HR _____ RR _____ TEMP _____ WT _____ HT _____ FHT _____

_____

RN

_____

_____

GENERAL	☐ Normal	☐ Abnormal	_____
HEAD/NECK	☐ Normal	☐ Abnormal	_____
LUNGS	☐ Normal	☐ Abnormal	_____
HEART	☐ Normal	☐ Abnormal	_____
EXTREMITIES	☐ Normal	☐ Abnormal	_____
REFLEXES	☐ Normal	☐ Abnormal	_____

IMPRESSION _____

PLAN _____

_____

_____

FUNDAL HEIGHT _____

VULVA _____

VAGINA _____

CERVIX: dil _____ cm Eff _____ %

Position ☐ Ant ☐ Mid ☐ Post

Pres _____ Station _____

MEMBRANES ☐ Intact ☐ Ruptured ☐ Clear ☐ MSF ☐ Bloody ☐ Foul

_____ MD/CNM

_____

653100-018 6/0

Short Stay Record

96313

SHANDS Jacksonville

Name: _____

Unit #: _____

Women's Acute Care
Obstetrical Short-Stay Record

Allergies: _____ Clinic: _____ EDC: _____

Date: _____ Time: _____ Age: _____ Gestation: _____

Reason for Visit / Chief Complaint _____

Gravida _____ Para _____ LMP _____ FHT _____

T _____ P _____ R _____ BP _____ Wt. _____ Ht. _____

U/A: Leukocytes _____ Protein _____ Glucose _____ Ketones _____ Blood _____

Date/ Time	Maternal Assessment				Fetal Assessment		Uterine Assessment				Vaginal Assessment				
	T	P	R	B/P	Baseline	Accels (+) or (-)	Freq	INT	DUR	Rest Tone	DIL	EFF	Station	POS	MEMB

Date / Time	Nurse's Notes	Nurse's Initials

Signature	Initials

653100

DATE/TIME	NURSE'S NOTES	SIGNATURE

NICA

NOTICE TO OBSTETRIC PATIENTS
(See Section 766.316, Florida Statutes)

I have been furnished information on behalf of **University of Florida College of Medicine physicians and certified nurse midwives** who practice obstetrics or perform obstetric services at **Shands Jacksonville**which have been prepared by the Florida Birth-Related Neurological Injury Compensation Association. I have also been advised that the **University of Florida College of Medicine physicians and certified midwives** who practice obstetrics or perform obstetric services are participating physicians in that program, wherein certain limited compensation is available in the event certain neurological injury may occur during labor, delivery or resuscitation. For specifics on the program, I understand I can contact the Florida Birth-Related Neurological Injury Compensation Association (NICA), 1435 Piedmont Drive East, Suite 101, Tallahassee, Florida 32312, 1-800-398-2129. I further acknowledge that I have received a copy of the brochure prepared by NICA.

DATED this _____ day of _____, 20____.

_____
Signature of Patient

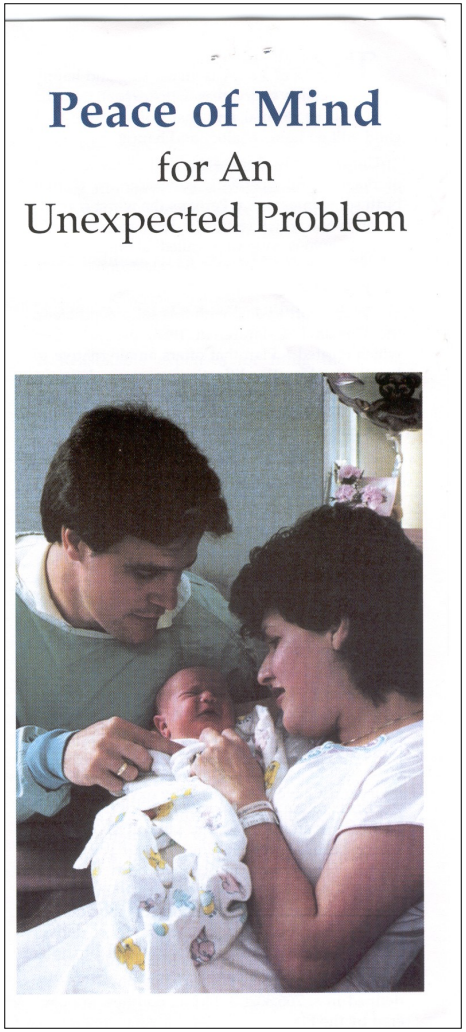
_____
Printed Name of Patient

_____
Patient's Social Security Number

_____ _____
Witness Date

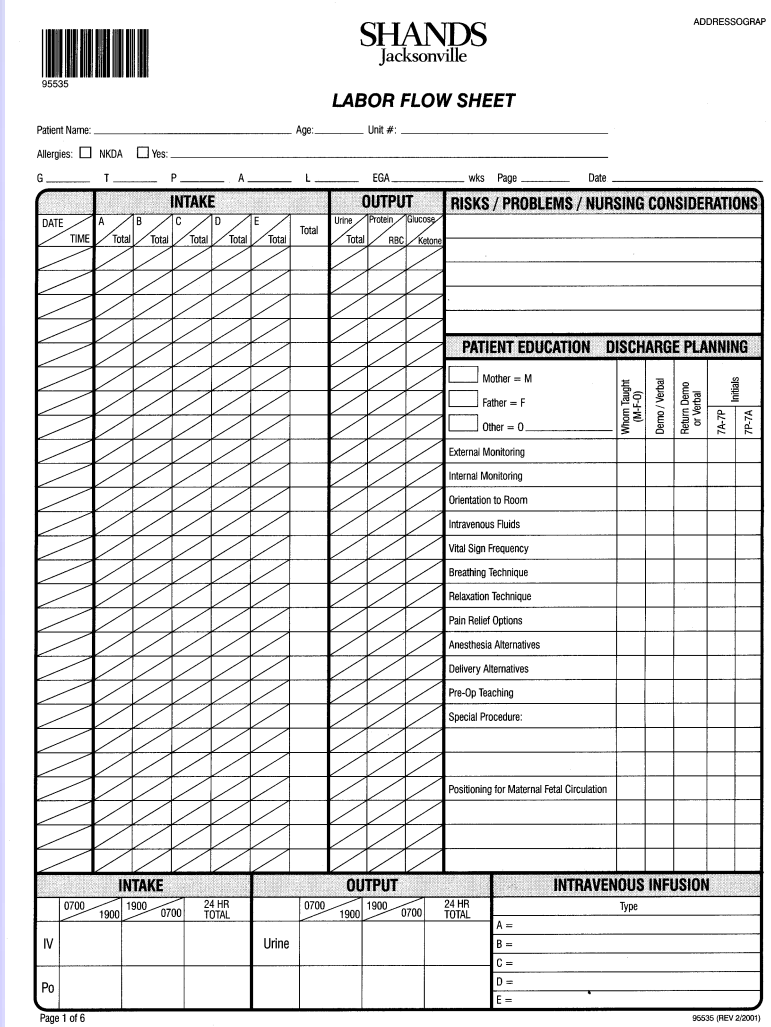
650500-006 9/00

Form for patient to sign – place in chart



Give patient a brochure

Labor Flow Sheets



95535

SHANDS Jacksonville

ADDRESSOGRAP

LABOR FLOW SHEET

Patient Name: _____ Age: _____ Unit #: _____

Allergies: ☐ NKDA ☐ Yes: _____

G _____ T _____ P _____ A _____ L _____ EGA _____ wks Page _____ Date _____

INTAKE

DATE / TIME | A Total | B Total | C Total | D Total | E Total | Total

OUTPUT

Urine Total | Protein RBC | Glucose Ketone

RISKS / PROBLEMS / NURSING CONSIDERATIONS

PATIENT EDUCATION DISCHARGE PLANNING

☐ Mother = M
☐ Father = F
☐ Other = O _____

	Whom Taught (M-F-O)	Demo / Verbal	Return Demo or Verbal	Initials 7A-7P	Initials 7P-7A
External Monitoring					
Internal Monitoring					
Orientation to Room					
Intravenous Fluids					
Vital Sign Frequency					
Breathing Technique					
Relaxation Technique					
Pain Relief Options					
Anesthesia Alternatives					
Delivery Alternatives					
Pre-Op Teaching					
Special Procedure:					
Positioning for Maternal Fetal Circulation					

INTAKE

	0700–1900	1900–0700	24 HR TOTAL
IV			
Po			

OUTPUT

	0700–1900	1900–0700	24 HR TOTAL
Urine			

INTRAVENOUS INFUSION

Type

A =
B =
C =
D =
E =

Page 1 of 6

95535 (REV 2/2001)

LONG TERM VARIABILITY
↓ = 0-5 BPM
+ = 6-25 BPM
↑ > 25 BPM

SHORT TERM VARIABILITY
+ = PRESENT
0 = ABSENT

ACCELERATIONS
+ = PRESENT (15 BPM x 15 sec)
Ø = ABSENT

MVU (MONTEVIDEO UNITS)
THE SUM OF THE PEAK OF EACH UTERINE CONTRACTION MINUS RESTING TONE, IN A 10 MIN. PERIOD

MEMBRANES
I = INTACT
M = MECONIUM
B = BULGING
RA = RUPTURED ARTIFICIAL
RS = RUPTURED SPONTANEOUS

AMNIOINFUSION RETURN
0 = NONE
1 = MINIMAL
2 = LARGE

DEEP TENDON REFLEXES
0 = ABSENT
+1 = SLUGGISH
+2 = NORMAL
+3 = HYPERACTIVE
+4 = BRISK

CLONUS
+ = PRESENT
Ø = ABSENT

EPIDURAL SIDE EFFECTS
P = PRURITUS
R = RESP RATE < 12
N = NAUSEA
H = HYPOTENSION

SEDATION SCALE
0 = FULLY ALERT
1 = AROUSES TO VOICE
2 = REQUIRES PHYS. STIM.
3 = UNAROUSABLE
4 = NORMAL SLEEP

PAIN RATING SCALE
0 = NO PAIN
10 = WORSE PAIN

MATERNAL POSITION
L = LEFT
R = RIGHT
SF = SEMI-FOWLER'S
HF = HIGH-FOWLER'S
T = TRENDELENBURG
KC = KNEE CHEST
RC = ROCKING CHAIR
C = CHAIR
S = SUPINE
X = POSITION CHANGE ENCOURAGED

MD/CNM NOTIFIED
+ = WITH PATIENT
N = NOTIFIED
0 = ORDERS RECEIVED
VR = VERBAL REPORT
SR = STRIP REVIEWED

DOCUMENTATION CODES
✓ = PERFORMED
* = SEE COMMENTS
↓ = CONTD AS PREVIOUSLY CHARTED
+ = PRESENT

DATE TIME	MATERNAL ASSESSMENT				FETAL ASSESSMENT					UTERINE ASSESSMENT						VAGINAL ASSESSMENT				
	Temp	Pulse	Resp	BP	EM / IFSE	Baseline	LTV	STV	Accels	EM / IUPC	Frequency	Intensity	MVU	Duration	Resting Tone	Dil. / Eff.	Station / POS	Memb	Amnio Infusion cc in	Amnio Infusion Return

Time / Init.	ACTION / ONE TIME MEDS Medication	Response to Med

EPIDURAL

Epidural Started @:
By:
Medication Dose:

Initial Dose

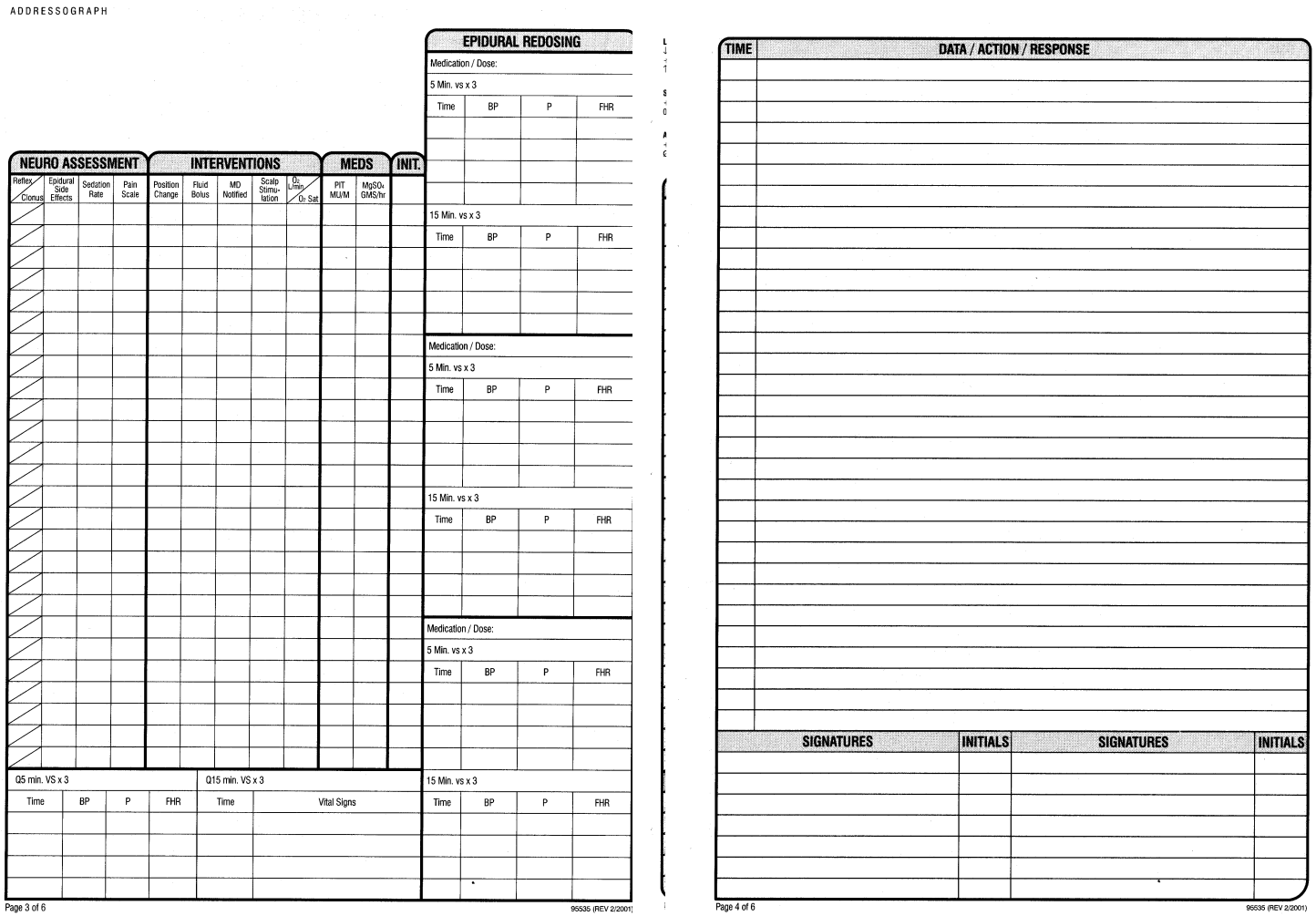
Time	BP	P	FHR

Page 2 of 6

95535 (REV 2/2001)

Be sure to date/time each entry

Labor Flow Sheets



ADDRESSOGRAPH

NEURO ASSESSMENT | **INTERVENTIONS** | **MEDS** | **INIT.**

Reflex / Clonus	Epidural Side Effects	Sedation Rate	Pain Scale	Position Change	Fluid Bolus	MD Notified	Scalp Stimulation	O2 L/min / O2 Sat	PIT MU/M	$MgSO_4$ GMS/hr	INIT.

EPIDURAL REDOSING

Medication / Dose:

5 Min. vs x 3

Time	BP	P	FHR

15 Min. vs x 3

Time	BP	P	FHR

Medication / Dose:

5 Min. vs x 3

Time	BP	P	FHR

15 Min. vs x 3

Time	BP	P	FHR

Medication / Dose:

5 Min. vs x 3

Time	BP	P	FHR

Q5 min. VS x 3

Time	BP	P	FHR

Q15 min. VS x 3

Time	Vital Signs

15 Min. vs x 3

Time	BP	P	FHR

Page 3 of 6

95535 (REV 2/2001)

TIME	DATA / ACTION / RESPONSE

SIGNATURES	INITIALS	SIGNATURES	INITIALS

Page 4 of 6

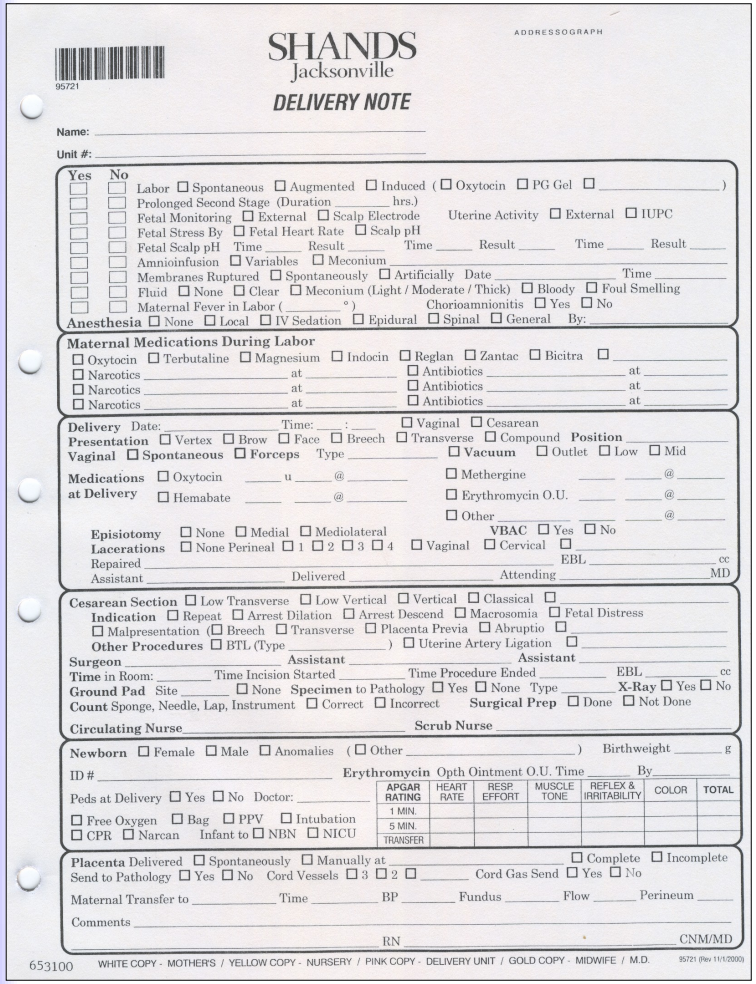
95535 (REV 2/2001)

Should be a “running” note each time MD at bedside, notified, or in response to concerning findings

Delivery Notes

- Date, time, route, instrumentation used
- Type (operative vs vaginal)
- Anesthesia, episiotomies, unusual events or complications, including use of forceps and vacuum extractor
- Assistants, others present
- Apgars, infant weight, estimated blood loss
- Disposition of mother and infant
- Receiving units: condition of patient (s) upon arrival from delivery room

Delivery Notes



95721

ADDRESSOGRAPH

SHANDS Jacksonville

DELIVERY NOTE

Name: _____

Unit #: _____

Yes No

☐ ☐ Labor ☐ Spontaneous ☐ Augmented ☐ Induced (☐ Oxytocin ☐ PG Gel ☐ _____)
☐ ☐ Prolonged Second Stage (Duration _____ hrs.)
☐ ☐ Fetal Monitoring ☐ External ☐ Scalp Electrode Uterine Activity ☐ External ☐ IUPC
☐ ☐ Fetal Stress By ☐ Fetal Heart Rate ☐ Scalp pH
☐ ☐ Fetal Scalp pH Time _____ Result _____ Time _____ Result _____ Time _____ Result _____
☐ ☐ Amnioinfusion ☐ Variables ☐ Meconium _____
☐ ☐ Membranes Ruptured ☐ Spontaneously ☐ Artificially Date _____ Time _____
☐ ☐ Fluid ☐ None ☐ Clear ☐ Meconium (Light / Moderate / Thick) ☐ Bloody ☐ Foul Smelling
☐ ☐ Maternal Fever in Labor (_____ °) Chorioamnionitis ☐ Yes ☐ No

Anesthesia ☐ None ☐ Local ☐ IV Sedation ☐ Epidural ☐ Spinal ☐ General By: _____

Maternal Medications During Labor

☐ Oxytocin ☐ Terbutaline ☐ Magnesium ☐ Indocin ☐ Reglan ☐ Zantac ☐ Bicitra ☐ _____
☐ Narcotics _____ at _____ ☐ Antibiotics _____ at _____
☐ Narcotics _____ at _____ ☐ Antibiotics _____ at _____
☐ Narcotics _____ at _____ ☐ Antibiotics _____ at _____

Delivery Date: _____ Time: ____ : ____ ☐ Vaginal ☐ Cesarean
Presentation ☐ Vertex ☐ Brow ☐ Face ☐ Breech ☐ Transverse ☐ Compound **Position** _____
Vaginal ☐ **Spontaneous** ☐ **Forceps** Type _____ ☐ **Vacuum** ☐ Outlet ☐ Low ☐ Mid

Medications at Delivery
☐ Oxytocin ____ u ____ @ ____ ☐ Methergine ____ ____ @ ____
☐ Hemabate ____ ____ @ ____ ☐ Erythromycin O.U. ____ ____ @ ____
☐ Other _____ ____ ____ @ ____

Episiotomy ☐ None ☐ Medial ☐ Mediolateral **VBAC** ☐ Yes ☐ No
Lacerations ☐ None Perineal ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Vaginal ☐ Cervical ☐ _____
Repaired _____ EBL _____ cc
Assistant _____ Delivered _____ Attending _____ MD

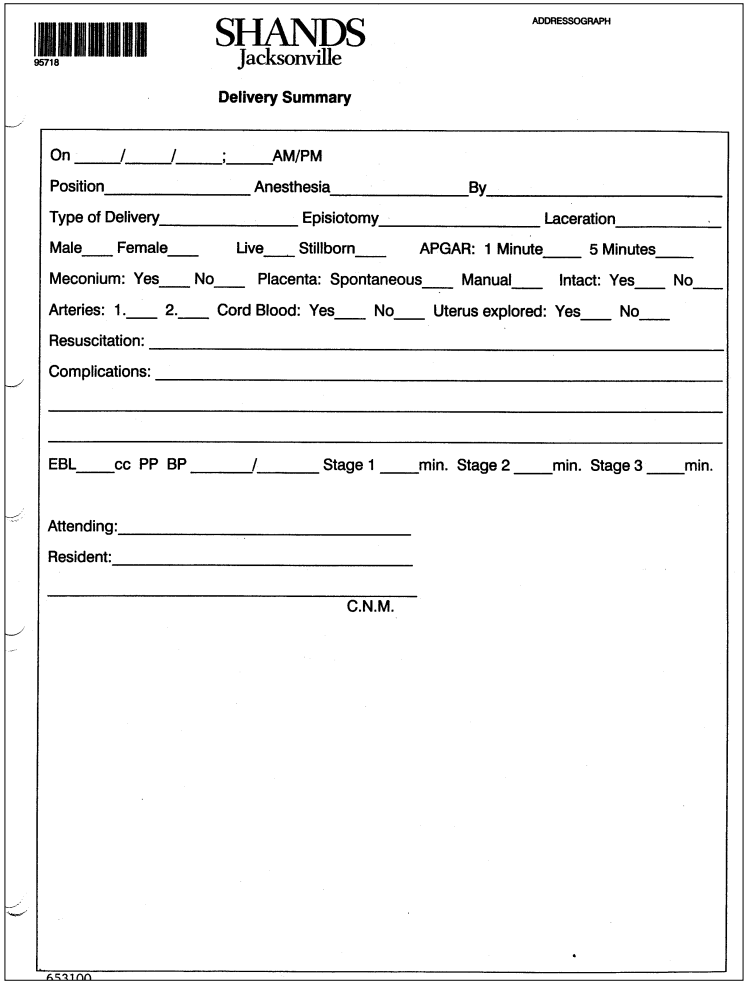
Cesarean Section ☐ Low Transverse ☐ Low Vertical ☐ Vertical ☐ Classical ☐ _____
Indication ☐ Repeat ☐ Arrest Dilation ☐ Arrest Descend ☐ Macrosomia ☐ Fetal Distress
☐ Malpresentation (☐ Breech ☐ Transverse ☐ Placenta Previa ☐ Abruptio ☐ _____
Other Procedures ☐ BTL (Type _____) ☐ Uterine Artery Ligation ☐ _____
Surgeon _____ **Assistant** _____ **Assistant** _____
Time in Room: _____ Time Incision Started _____ Time Procedure Ended _____ EBL _____ cc
Ground Pad Site _____ ☐ None **Specimen** to Pathology ☐ Yes ☐ None Type _____ **X-Ray** ☐ Yes ☐ No
Count Sponge, Needle, Lap, Instrument ☐ Correct ☐ Incorrect **Surgical Prep** ☐ Done ☐ Not Done
Circulating Nurse _____ **Scrub Nurse** _____

Newborn ☐ Female ☐ Male ☐ Anomalies (☐ Other _____) Birthweight _____ g
ID # _____ **Erythromycin** Opth Ointment O.U. Time _____ By _____
Peds at Delivery ☐ Yes ☐ No Doctor: _____
☐ Free Oxygen ☐ Bag ☐ PPV ☐ Intubation
☐ CPR ☐ Narcan Infant to ☐ NBN ☐ NICU

APGAR RATING	HEART RATE	RESP. EFFORT	MUSCLE TONE	REFLEX & IRRITABILITY	COLOR	TOTAL
1 MIN.						
5 MIN.						
TRANSFER						

Placenta Delivered ☐ Spontaneously ☐ Manually at _____ ☐ Complete ☐ Incomplete
Send to Pathology ☐ Yes ☐ No Cord Vessels ☐ 3 ☐ 2 ☐ _____ Cord Gas Send ☐ Yes ☐ No
Maternal Transfer to _____ Time _____ BP _____ Fundus _____ Flow _____ Perineum _____
Comments _____
_____ RN _____ CNM/MD

653100 WHITE COPY - MOTHERS / YELLOW COPY - NURSERY / PINK COPY - DELIVERY UNIT / GOLD COPY - MIDWIFE / M.D. 95721 (Rev 11/1/2000)



95718

ADDRESSOGRAPH

SHANDS Jacksonville

Delivery Summary

On ____/____/____;____AM/PM

Position_____ Anesthesia_____ By_____

Type of Delivery_____ Episiotomy_____ Laceration_____

Male___ Female___ Live___ Stillborn___ APGAR: 1 Minute____ 5 Minutes____

Meconium: Yes___ No___ Placenta: Spontaneous___ Manual___ Intact: Yes___ No___

Arteries: 1.___ 2.___ Cord Blood: Yes___ No___ Uterus explored: Yes___ No___

Resuscitation: _____

Complications: _____

_____

_____

EBL____cc PP BP _____/_____ Stage 1 ____min. Stage 2 ____min. Stage 3 ____min.

Attending:_____

Resident:_____

_____
C.N.M.

653100

Fetal Monitor Strips

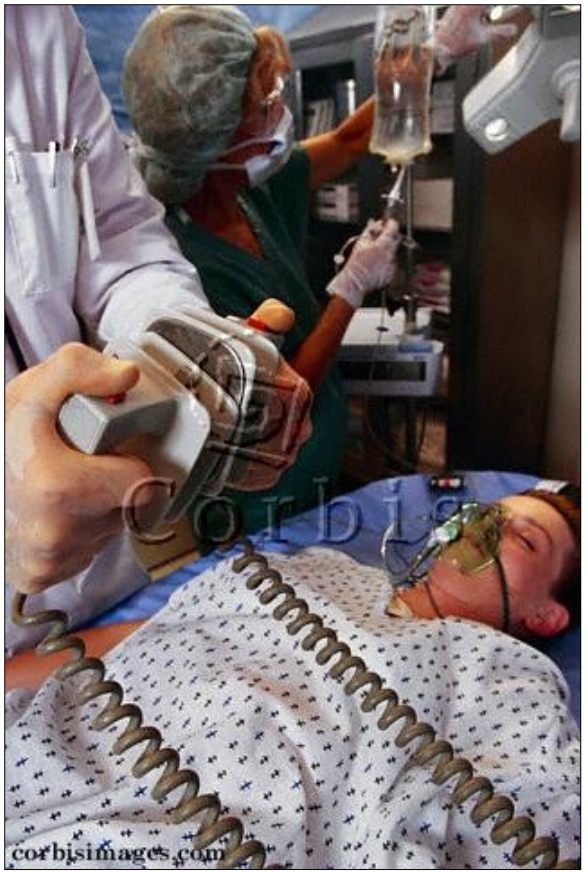
- Label with patient name, date and time
- Don’t use notations on strips as substitution for what should be in progress/”running” notes
- When concerning finding on strips, should have corresponding “running” note to indicate what was done and MD notified
- If MD does not appropriately respond, initiate “Chain of Command” and so document in chart
- Strips must remain with record

Adverse Incidents

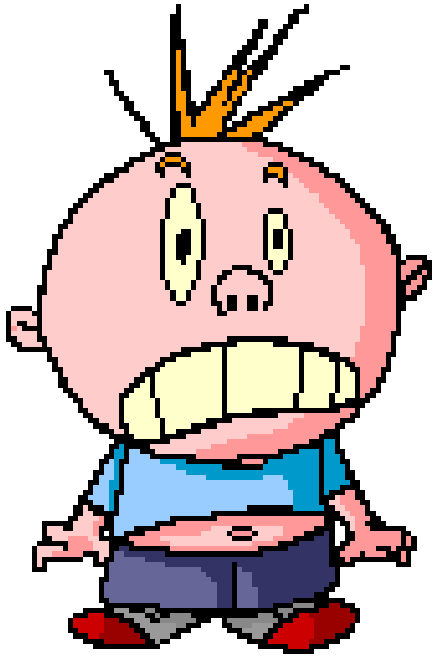
- Adverse incidents do not necessarily involve negligence
- Document facts briefly, objectively
- Document physical examination of patient by physician and/or nurse in follow-up when necessary
- Clearly state if no injury is present
- Notify charge/nurse manager
- Complete RAQ report but do not make reference to the report in the chart
- Notify risk management –

Complications

- Document complication completely/objectively – no judgment calls
- Document patient was informed of complication and its implications
- Treat the complication like any other physical problem; document it as such until resolved



Disagreements



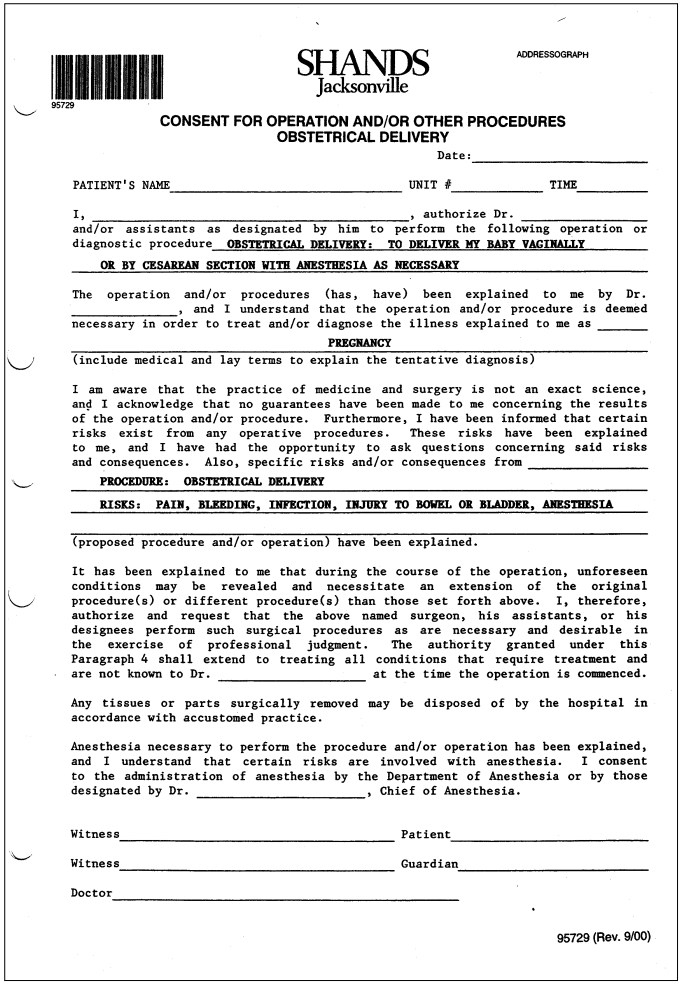
- They shouldn’t be reflected in the chart
- Differences of opinion should be documented professionally

Integrity of Record

- All pages labeled with full patient name and medical record number
- Do not pull out pages as it increase risks of permanent separation
- Chart only on approved forms
- Use ballpoint pens
- Attach all strips such as FMS, ECG, etc.

Consent

- Physician non-delegable duty
  - Who obtained, who will perform procedure
  - Name of procedure
  - Potential benefits
  - Significant risks
  - Reasonable alternatives
  - If emergency didn't allow consent, indicate so in record
- If not English-speaking, document how translation was provided
- Nurse confirms patient's understanding and witnesses patient's signature on form
- If questions, get MD



95729

SHANDS Jacksonville

ADDRESSOGRAPH

CONSENT FOR OPERATION AND/OR OTHER PROCEDURES
OBSTETRICAL DELIVERY

Date:_____

PATIENT'S NAME_____ UNIT #_____ TIME_____

I, _____, authorize Dr. _____ and/or assistants as designated by him to perform the following operation or diagnostic procedure **OBSTETRICAL DELIVERY: TO DELIVER MY BABY VAGINALLY OR BY CESAREAN SECTION WITH ANESTHESIA AS NECESSARY**

The operation and/or procedures (has, have) been explained to me by Dr. _____, and I understand that the operation and/or procedure is deemed necessary in order to treat and/or diagnose the illness explained to me as **PREGNANCY**

(include medical and lay terms to explain the tentative diagnosis)

I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the operation and/or procedure. Furthermore, I have been informed that certain risks exist from any operative procedures. These risks have been explained to me, and I have had the opportunity to ask questions concerning said risks and consequences. Also, specific risks and/or consequences from **PROCEDURE: OBSTETRICAL DELIVERY**

RISKS: PAIN, BLEEDING, INFECTION, INJURY TO BOWEL OR BLADDER, ANESTHESIA

(proposed procedure and/or operation) have been explained.

It has been explained to me that during the course of the operation, unforeseen conditions may be revealed and necessitate an extension of the original procedure(s) or different procedure(s) than those set forth above. I, therefore, authorize and request that the above named surgeon, his assistants, or his designees perform such surgical procedures as are necessary and desirable in the exercise of professional judgment. The authority granted under this Paragraph 4 shall extend to treating all conditions that require treatment and are not known to Dr. _____ at the time the operation is commenced.

Any tissues or parts surgically removed may be disposed of by the hospital in accordance with accustomed practice.

Anesthesia necessary to perform the procedure and/or operation has been explained, and I understand that certain risks are involved with anesthesia. I consent to the administration of anesthesia by the Department of Anesthesia or by those designated by Dr. _____, Chief of Anesthesia.

Witness_____ Patient_____

Witness_____ Guardian_____

Doctor_____

95729 (Rev. 9/00)

Summary: Just for Fun

Exam of genitalia reveals that he is circus sized

She had no rigors or shaking but her husband said she was hot in bed.

Discharge status, alive but without permission

Large brown stool ambulating in the hall

Questions?